Complete Summary

GUIDELINE TITLE

Prostate cancer.

BIBLIOGRAPHIC SOURCE(S)

Dutch Urological Association. Prostate cancer. Utrecht, The Netherlands: Association of Comprehensive Cancer Centres; 2007 Jul 23. 142 p. [529 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

METHODOLOGY - including Rating Scheme and Cost Analysis
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SCOPE

DISEASE/CONDITION(S)

Prostate cancer

GUIDELINE CATEGORY

Counseling Diagnosis Management Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Nuclear Medicine
Nursing
Oncology
Pathology
Psychology
Radiation Oncology
Radiology
Urology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Patients
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers

GUIDELINE OBJECTIVE(S)

To provide guidance for daily practice that is applicable to all patients with prostate cancer, irrespective of stage

TARGET POPULATION

Patients with prostate cancer

INTERVENTIONS AND PRACTICES CONSIDERED

Diagnosis

- 1. Patient history
- 2. Physical examination for diagnosis and staging
 - Digital rectal examination
 - Gleason score
- 3. Diagnostic tests
 - Prostate specific antigen (PSA)
 - Transrectal grey-scale ultrasound
 - Contrast-enhanced transrectal ultrasound, color Doppler, power Doppler (considered but not recommended)
 - Computed tomography
 - Magnetic resonance imaging
 - Skeletal scintigraphy (bone scan)
 - Pathological assessment of biopsies, transurethral resection of the prostate (TURP) material, and prostatectomy specimens

Counseling and Supportive Care

- 1. Provision of information on results and consequences of treatment options
- 2. Structured multidisciplinary review
- 3. Lifestyle modification (diet, exercise, smoking cessation)
- 4. Psychosocial care for disease- or treatment-related sexual dysfunction, urinary symptoms, gastrointestinal symptoms, and course of the disease

Management/Treatment

- 1. Treatment of localized prostate cancer
 - Active monitoring
 - Surgery
 - External beam radiotherapy
 - Brachytherapy
- 2. Treatment of locally advanced prostate cancer
 - Lymph node dissection
 - Radical prostatectomy
 - Adjuvant radiotherapy after radical prostatectomy
 - Adjuvant hormone therapy after radical prostatectomy
 - External radiotherapy
 - Adjuvant or neoadjuvant hormone therapy with radiotherapy
 - Hormone therapy
 - Follow-up (duration, PSA assessment)
- 3. Treatment of local recurrence of prostate cancer
 - PSA measurement to determine recurrence after radical prostatectomy
 - External beam radiation therapy (EBRT)
 - Radical salvage prostatectomy after EBRT
 - Salvage brachytherapy after EBRT
- 4. Treatment of metastatic prostate cancer
 - Hormone therapy
 - Intravenous bisphosphonates
 - Radiotherapy
 - Chemotherapy (docetaxel + prednisone)
 - Palliative therapy

The use of contrast-enhanced transrectal ultrasound, color Doppler, power Doppler ultrasound, for diagnosis, treatment of localized prostate cancer with adjuvant or neoadjuvant hormone therapy and treatment of local recurrence of prostate cancer with hormone therapy were considered but not recommended.

MAJOR OUTCOMES CONSIDERED

- Gleason score
- Incidence and prevalence of localized prostate cancer, locally advanced prostate cancer, recurrence of prostate cancer, and metastatic prostate cancer
- Tumor grade and stage
- Adverse effects and complications of treatments
- Recurrence rate
- Disease- and treatment-related psychosocial issues
- Mortality

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources) Hand-searches of Published Literature (Secondary Sources)

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Relevant articles were found by performing systematic searches in the Cochrane Library, Medline, and Embase. Manual searches were also performed. Articles were extracted from the reference lists of the articles retrieved, and articles already in the possession of working group members were included. Other guidelines on prostate cancer were also consulted. For most chapters, the searches covered the last 15 years; in some cases earlier articles were searched. Articles were selected based on the following criteria: (a) articles published predominantly in English or Dutch and (b) use of full published articles whenever possible.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence

For articles regarding intervention	
A1	Systematic reviews covering at least some A2-level studies in which the results of the individual studies are consistent
A2	Randomised comparative clinical studies of good quality (double-blind, controlled), sufficient size and consistency
В	Randomised clinical trials of moderate quality or insufficient size, or other comparative studies (non-randomised, comparative cohort studies, patient-control studies)
С	Non-comparative studies
D	Expert opinion from, for example, working group members
For articles regarding diagnosis	
A1	Studies on the effects of diagnosis on clinical outcomes in a prospectively followed, well-defined patient population with a predefined protocol based on the results of the study test, or decision theory studies on the effects of diagnosis on

- clinical outcomes based on the results of A2-level studies with sufficient consideration given to the interaction between diagnostic tests
- A2 Studies that include a reference test with predefined criteria for the study test and the reference test and a good description of the test and the clinical population studied; a sufficiently large series of consecutive patients must be included, predefined cut-off values must be used and the results of the test and the gold standard must be evaluated independently. For situations in which multiple diagnostic tests are involved, there is in principle interaction and the analysis should take this into account by using, for example, logistical regression
- **B** Comparison with a reference test and description of the study test and population, but lacking the other characteristics of A-level studies
- **C** Non-comparative studies
- **D** Expert opinion from, for example, working group members

Level of evidence for conclusions

- At least 1 systematic review (A1) or 2 independently conducted A1- or A2-level studies
- 2 At least 2 independently conducted B-level studies
- **3** At least 1 A2-, B- or C-level study
- **4** Expert opinion from, for example, working group members

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Systematic literature searches were performed and the quality and content of the articles retrieved was judged by working group members using the evidence-based guideline evaluation form

(www.cbo.nl/product/richtlijnen/handleiding_ebro). Articles of mediocre or poor quality were excluded. After this selection process, the remaining articles were then used as the basis for the various conclusions stated in the guideline. The selected articles were then graded according to the level of evidence using the classification in "Rating Scheme for the Strength of Evidence" field.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The working group formulated basic questions for each chapter. To develop each chapter, subgroups were formed with representatives from relevant disciplines. These subgroups worked on developing a draft text for a specific part of the guideline for 2 years beginning in January 2003. Working group members then

wrote a section or chapter of the draft guideline, which incorporated the literature found. During plenary meetings, subgroups justified their own text and commented on other chapters. The editorial team collected the texts developed by the subgroups and made any necessary changes for consistency to ultimately create one document: the draft guideline.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The draft guideline was disseminated for commentary among the relevant professional organisations and regional working groups on urological tumours. It was presented at a national guideline conference on 18 October 2006. All members of relevant professional societies were invited to this conference either personally or via an announcement in a trade journal. The comments made at this conference were incorporated into the draft to create the definitive guideline.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Diagnosis

1.1.1 Which patient history factors are relevant for the diagnosis of prostate cancer?

A family history should be taken for every patient suspected of having prostate cancer. Patients with a family history indicative of hereditary prostate cancer should undergo periodic evaluation according to the recommendations formulated by the Netherlands Foundation for the Detection of Hereditary Tumours ("Stichting Opsporing Erfelijke Tumoren").

1.1.2 Which physical examination factors are relevant for diagnosis and staging?

Digital rectal examination (DRE) should be performed in men suspected of having prostate cancer as one component of a targeted physical examination. Consideration should be given to the low sensitivity and limited predictive value of

DRE in the detection of prostate cancer, particularly in an unselected population (screening).

1.2.1 Can digital rectal examination be performed prior to PSA assessment?

Given that DRE has little effect on total serum prostate specific antigen (PSA) level, the DRE can be performed prior to blood collection.

1.3.1.1 What is the additional diagnostic value of transrectal grey-scale ultrasound (TRUS) in the diagnosis and staging of prostate cancer?

Transrectal grey-scale ultrasound must be used to guide prostate biopsies.

1.3.1.2 What is the additional diagnostic value of colour Doppler, power Doppler, and contrast-enhanced transrectal ultrasound in the diagnosis and staging of prostate cancer?

Use of contrast-enhanced ultrasound to direct biopsies of hypervascular regions cannot yet be recommended for general practice for the diagnosis and staging of prostate cancer.

1.3.2 For which patients should a computed tomography (CT) scan be made in the diagnosis and staging of prostate cancer?

Use of a CT scan is not recommended for the diagnosis of prostate cancer or for tumour and lymph node staging.

A CT scan can be useful in guiding lymph node biopsy for nodes suspected of containing metastases.

1.3.3.1 For which patients should magnetic resonance imaging (MRI) be used in the diagnosis and staging of prostate cancer?

If the biopsy result is negative but a clinical suspicion of prostate cancer remains, endorectal MRI with a field strength of 1.5 tesla can be used (if available) before performing a second biopsy.

Patients with an intermediate-to-high risk of tumour invasion beyond the prostate may undergo endorectal MRI with a field strength of at least 1.5 tesla (if available) prior to therapy. If available, the use of a 3-tesla MRI may also be considered for low-risk patients, given its higher sensitivity and comparable specificity.

Conventional MRI for lymph node staging should only be used in patients with an a priori risk greater than 40%.

Localisation of the carcinoma within the prostate for therapeutic purposes is preferably determined by MRI.

1.3.4 For which patients should a bone scan be made in the diagnosis and staging of prostate cancer?

Routine use of skeletal scintigraphy in the primary diagnosis of prostate cancer is not advisable. Skeletal scintigraphy is only recommended to confirm or exclude the presence of bone metastases in patients with a PSA level of 20 ng/mL or more, a locally advanced tumour, Gleason score of 8 or more, or symptomatic bone pain.

1.4.2 When is a repeat biopsy indicated?

Extension of the sextant biopsy to include two extra bilateral biopsies, preferably of the anterolateral peripheral zone, is recommended.

If malignancy is clinically suspected, the serial biopsy should be repeated at least once. Performing additional repeat biopsies depends on the degree of suspicion.

Reporting the presence of high-grade prostatic intra-epithelial neoplasia (HGPIN) in a prostate needle biopsy without prostate cancer is recommended. Repeat biopsy following a diagnosis of multifocal HGPIN is recommended. For a pathologic diagnosis of 'suspected malignancy', the serial biopsy should be repeated at least once with extra biopsies from the suspected region.

The location of the prostate needle biopsy should be reported not only as left or right, but also in regard to the segment (apex, mid-prostate, base).

1.4.2.1 Gleason score

The Gleason score and its components are used to grade prostate cancer and assess the prostate needle biopsy.

1.4.2.2 Other histopathological prognostic factors

The pathology report should include the number of biopsies containing tumour and the amount of tumour (expressed as length in mm or percentage of volume) for the left and right sides.

1.4.2.3 Assessment of biopsies, transurethral resection of the prostate (TURP) samples, and prostatectomy specimens

Sectioning occurs at a minimum of three levels. From each level, blank bands and/or sections are saved for immunohistochemistry.

TURP samples are first embedded in 8 cassettes. Embedding the remaining tissue is advisable for a diagnosis of pT1a - but not pT1b - tumours.

If feasible, the entire prostate should be assessed histologically.

The Gleason score is used to grade prostate cancer in radical prostatectomy samples. It is recommended to provide a Gleason score for each individual tumour

and to separately report the presence of a higher grade (4 or 5) as a tertiary component.

Calculating tumour volume is not recommended. To provide an indication of tumour size, the pathology report should contain the maximum diameter of the tumour(s).

Prostate cancer is staged according to the most recent version of TNM staging (2002 or later). It is also recommended to report the extent of extracapsular invasion.

The presence, location, and extent of positive resection margins following radical prostatectomy for prostate cancer should be reported.

A positive resection margin without the capsule is not staged as pT3a but as pT2X or pT2+ to indicate that it is unclear whether there has been invasion beyond the prostate.

1.5 Nursing, supportive care, and counseling

To support the treatment decision-making process, patient counselling must include quantitative data on the results and consequences of various treatment options specific to the treating clinic.

In addition to the treating physician, the nurse specialist plays an important role in counselling and educating men with prostate cancer.

It is advisable to report in the patient's medical record who provided counselling and which treatment options and expected adverse events were discussed.

A structured multidisciplinary review is desirable for the management of patients with prostate cancer.

Treatment of Localised Prostate Cancer

2.1.1 What are the expected outcomes of active monitoring in patients with localised prostate cancer?

Active monitoring is preferred for patients with low risk (T1c-2a, Gleason <7, PSA <10 ng/mL) with advanced age (>75 years). With this approach, the patient should be informed that life expectancy is not determined by the prostate cancer and that each treatment is associated with a risk of adverse effects. Active monitoring may also be considered for patients with moderate or high risk disease if they have obvious comorbidity and advanced age, which negatively influences life expectancy.

2.1.2.1 Relationship between volume and quality for prostatectomy

To determine the role of radical prostatectomy as a treatment option for patients with localised prostate cancer, the advantages and disadvantages of the various

treatment options, including external radiotherapy and brachytherapy, must be weighed against active monitoring.

Radical prostatectomy is performed preferably in institutions that perform this procedure routinely.

The laparoscopic procedure should be performed routinely by an established team in order to obtain and maintain good results.

2.1.3 What are the expected outcomes of external radiotherapy in patients with localised prostate cancer?

To determine the role of external radiotherapy as a treatment option in patients with localised prostate cancer, the advantages and disadvantages of various treatment options, including radical prostatectomy and brachytherapy, must be weighed against active monitoring.

The working group cannot make any recommendations regarding the minimum number of patients who must undergo external radiotherapy for localised prostate cancer annually.

2.1.4 What are the expected outcomes of brachytherapy in patients with localised prostate cancer?

To determine the role of brachytherapy as a treatment option for patients with localised prostate cancer, the advantages and disadvantages of various treatment options, including radical prostatectomy and external radiotherapy, must be weighed against active monitoring.

2.1.4.1 Relationship between volume and quality for brachytherapy

The working group advises that brachytherapy is performed routinely to maintain sufficient experience and to be able to manage possible complications following treatment.

2.1.5 What are the expected outcomes of adjuvant or neoadjuvant hormone therapy in patients with localised prostate cancer?

Adjuvant or neoadjuvant hormone therapy is not recommended for patients with low- or moderate-risk localised prostate cancer.

2.3 What is the optimal treatment for patients with T1-2 localised prostate cancer, accounting for level of risk and the risk of treatment-related harm?

Based on the available evidence on the treatment of patients with localised prostate cancer, the working group cannot make any recommendations regarding which treatment is preferred. The working group also cannot recommend a specific treatment based on the reported adverse events and complications.

The choice of treatment is determined after consultation with the patient whom the physician should inform thoroughly and as objectively as possible regarding the efficacy and toxicity of each treatment modality. The patient's age and general condition are taken into account in the decision, particularly when considering the option of withholding treatment.

2.4 Nursing, supportive care, counselling, and communication

Counselling and education after treatment for localised prostate cancer should be tailored to the individual preferences and needs of the patient.

Specific attention should be given to the presence of postoperative pain, urinary symptoms, catheter care, incontinence, and erectile dysfunction.

The patient's medical record should include who has provided counselling and what was discussed. The treatment options and expected adverse events that were discussed should also be documented.

Treatment of Locally Advanced Prostate Cancer

3.1 When is lymph node dissection indicated?

Lymph node dissection is indicated if the results may affect treatment decisions. Risk estimation for the presence of positive lymph nodes is made using nomograms, such as the Kattan nomograms.

3.2.1 What are the results of radical prostatectomy for cT3 tumours?

In general, radical prostatectomy is not an option for patients with cT3 tumours. Surgery should be performed only for specific cases.

3.2.2 Neoadjuvant hormone therapy before radical prostatectomy for cT3 prostate cancer

Neoadjuvant hormone therapy prior to radical prostatectomy should not be given to patients with cT3 prostate cancer.

3.2.3 Which patients with pT3 tumours will benefit from adjuvant radiotherapy after radical prostatectomy?

Adjuvant radiotherapy is an option for patients with pT3 prostate cancer.

3.2.4 Adjuvant hormone therapy after radical prostatectomy for pT3 prostate cancer

Adjuvant hormone therapy is not recommended for pT3 tumours.

3.3.1 What are the results of external radiotherapy for cT3 tumours?

Patients with locally advanced prostate cancer should be offered radiotherapy.

Patients with locally advanced prostate cancer should undergo external radiotherapy, whereby at least 70 Gy are delivered to the prostate.

3.3.2 Which patients with locally advanced prostate cancer will benefit from adjuvant or neoadjuvant hormone therapy with radiotherapy?

The addition of hormone therapy to radiotherapy should be offered primarily to patients with a Gleason score of 7-10.

Determining the best timing and duration of adjuvant hormone therapy should be made in consultation with the patient, who should be well informed. It should be communicated to the patient that the optimal approach is unknown, and an approach that is most acceptable to the patient will be chosen.

3.4 Hormone therapy

Hormone therapy is a treatment option for patients with cT3 prostate cancer who refuse external radiotherapy or for whom external radiotherapy is contraindicated. Given the risk of adverse events associated with hormone therapy, delayed initiation of therapy is preferred.

What are the results of active monitoring without treatment in cT3 tumours?

Active monitoring and initiation of hormone therapy when symptoms or metastases arise can be considered for patients with limited life expectancy (<10 years).

Follow-up

4.1.2 Duration of follow-up

After treatment for prostate cancer, a general follow-up schema is recommended consisting of check-ups after 6 weeks; 3, 6, 9, and 12 months; and semi-annually or annually thereafter for 5 to 10 years. During the first check-up after 6 weeks, the clinician should inquire about symptoms and provide additional education on the disease and possible consequences of treatment.

For patients with demonstrated recurrence, the follow-up schema should be tailored to the individual patient based on symptoms, prognosis, and the type of treatment used.

Comparison of the efficacy and safety of different treatment modalities for localised prostate cancer requires a follow-up of at least 10 years after the PSA nadir has been reached.

4.2.1 PSA assessment

Men with prostate cancer should undergo PSA assessment at each follow-up visit.

4.2.2 Other follow-up tests

For patients with decreasing or low, stable PSA, DRE and other additional tests are not necessary. Additional imaging may be of value as indicated based on symptoms.

Biopsy of the prostate or prostate bed should be performed only if a positive result would influence the decision to initiate salvage therapy.

4.3 Which nursing, supportive care, and lifestyle advice should be provided?

Men with prostate cancer should be advised to follow a healthy and varied diet, get sufficient physical activity, and not smoke.

4.4 What are the requirements for organisation, cooperation, and communication?

Follow-up may involve various disciplines, such as oncology nurses, urology nurses, radiotherapy nurses, dieticians, physiotherapists, psychologists, and sexologists, depending on the specific problems, symptoms, and needs of the individual patient.

If the PSA level is stable (or increasing only very slightly), a general practitioner and/or specialised nurse may be asked to perform the annual PSA assessment after the PSA nadir has been reached.

At the beginning of the follow-up period, the goal, frequency, and duration of follow-up visits should be determined, as well as who will conduct the follow-up (e.g., urologist, radiation oncologist, others).

The patient must know what types of specific adverse event may occur, and to which care provider he should report them.

Treatment of Local Recurrence of Prostate Cancer

5.1.1 How is PSA recurrence diagnosed after radical prostatectomy?

To diagnose PSA recurrence after radical prostatectomy requires two PSA tests of >0.2 ng/mL with an interval of 2 to 3 months.

If the PSA doubling time is less than 10 months, it is likely that metastases or micrometastases are present.

5.1.2 Which additional tests are indicated for PSA recurrence after radical prostatectomy?

Biopsy of the prostate bed, ultrasound of the prostatic region, and DRE are not required to diagnose local recurrence after radical prostatectomy if the PSA level is low (<2.0 ng/mL).

Requesting a bone scan is not necessary for asymptomatic patients with PSA recurrence after radical prostatectomy and PSA <20 ng/mL.

Given its low sensitivity for detecting local recurrence in patients with PSA recurrence after radical prostatectomy, CT scan of the lower abdomen is not recommended.

MRI is not recommended for detecting local recurrence.

5.1.3 What is the optimal treatment of patients with PSA recurrence after radical prostatectomy?

External radiotherapy may be considered for patients with PSA recurrence after radical prostatectomy suspected of having local recurrence, provided that the PSA value is <1.0 ng/mL.

Hormone therapy is not recommended for the treatment of PSA recurrence.

5.2.1 How is PSA recurrence diagnosed after external radiotherapy?

PSA dynamics after external beam radiation therapy (EBRT) must be interpreted with caution given the phenomenon of PSA bounce. Increased PSA must be seen in three consecutive measurements made at least 3 months apart before PSA recurrence after EBRT can be diagnosed.

5.2.2 Which additional tests are indicated for PSA recurrence after EBRT?

DRE, prostate ultrasound, or CT scan are not recommended for PSA recurrence after FBRT.

Bone scan is not useful in patients with PSA recurrence after EBRT and no specific symptoms and PSA < 20 ng/mL.

Prostate biopsy after EBRT is indicated if treatment, such as salvage prostatectomy, is considered.

5.2.3.2 Radical salvage prostatectomy for local recurrence following EBRT

The decision to perform salvage prostatectomy is made on an individual basis, considering the patient's life expectancy, comorbidity, and tumour characteristics as well as the patient's assessment of the benefits and risks of this intervention. Centralisation of this intervention is preferred.

5.2.3.3 Salvage brachytherapy following recurrence after EBRT

The decision to perform salvage brachytherapy is made on an individual basis, considering the patient's life expectancy, comorbidity, and tumour characteristics as well as the patient's assessment of the benefits and risks of this intervention. Centralisation of this intervention is preferred.

5.2.3.4 Hormone therapy

Hormone therapy is not recommended for patients with PSA recurrence. If the patient wishes to receive hormone therapy, the benefits and risks of adjuvant hormone therapy must be weighed against active monitoring.

5.3.1 How is PSA recurrence diagnosed after brachytherapy?

PSA dynamics after brachytherapy should be interpreted with caution due to the phenomenon of PSA bounce. Increased PSA must be seen in three consecutive measurements made at least 3 months apart before PSA recurrence after brachytherapy can be diagnosed.

5.3.2 What is the optimal treatment of patients with local recurrence after brachytherapy?

Salvage treatment after brachytherapy may be considered only after a long interval (4-5 years).

The choice of therapy for patients with local recurrence following brachytherapy is made on an individual basis, considering the patient's life expectancy, comorbidity, and tumour characteristics. The benefits and risks of treatment should be weighed against active monitoring.

Treatment of Metastatic Prostate Cancer

6.1.1 What is the optimal type of hormone therapy?

Hormone therapy is the treatment of choice for patients with metastatic prostate cancer. The preferred methods are bilateral orchiectomy, luteinising hormone releasing hormone (LHRH) analogue, or parenteral oestrogen.

Maximal androgen blockade is not recommended as first-line therapy.

6.1.2 What is the optimal timing of hormone therapy?

The time to start hormone therapy is determined on an individual basis.

6.1.3 What is the optimal schedule of hormone therapy?

Intermittent hormone therapy for patients with metastatic prostate cancer is an experimental approach that is preferably given in the context of a clinical trial only.

6.2.1 Should hormone therapy be continued in patients who develop hormone-resistant metastatic prostate cancer (HRPC)?

Hormone therapy should be continued in patients with HRPC.

6.2.2. Is secondary hormone therapy beneficial in patients with HRPC?

Treatment with prednisone 5 mg twice daily should be considered for patients with symptomatic, advanced stage HRPC.

6.2.3. Is radiotherapy beneficial in patients with HRPC?

A single dose of 8 Gy is recommended for patients with a limited number (1-3) of painful bone metastases.

Use of radionuclides may be considered for patients with multiple painful bone metastases for whom conventional analgesics are insufficient, local radiotherapy is not possible, and chemotherapy is no longer an option.

6.2.4. Is chemotherapy beneficial for patients with HRPC?

Patients with HRPC may be offered treatment with docetaxel given at a dose of 75 mg/m² every 3 weeks combined with prednisone given at a dose of 5 mg twice daily. The combination of docetaxel and estramustine is not recommended given the increased risk of adverse events.

Asymptomatic patients with HRPC who refuse docetaxel/prednisone are preferably treated with watchful waiting and symptom management.

6.2.5 Is treatment with bisphosphonates beneficial in patients with HRPC?

Intravenous nitrogen-containing bisphosphonates may be used for patients with HRPC and bone pain due to skeletal metastases.

Psychosocial Care

It is advisable to assume that men with prostate cancer have specific psychosocial issues arising from disease- or treatment-related sexual dysfunction, urinary symptoms, gastrointestinal symptoms, and the slow course of the disease.

Men with prostate cancer should be provided with sufficient counselling regarding the disease, treatment options, and the possible side effects of treatment.

Men and their partners should be made aware of the educational materials available, the time and location of educational meetings, the services provided by patient organisations, and the contact information for discussion groups.

Involving men and their partners in treatment decisions is recommended.

Specialised (oncology or urology) nurses can play an important role in the detection of psychosocial issues and in counselling men and their partners on the disease and treatment.

The emotional processing and functioning of the partner of a man with prostate cancer warrants explicit attention in the management of the disease.

Participation in group meetings or support groups may be offered to men with prostate cancer to gain more social support and enhance emotional processing of the disease and the consequences of therapy.

Implementation and Indicators

The working group recommends that all relevant societies develop an implementation plan that is compatible with the aforementioned initiatives, and subsequently initiate an evaluation of implementation.

The working group recommends converting parts of the guideline into protocols where appropriate, while taking local conditions into account.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The scientific evidence and the level of the most relevant evidence is summarized in the "conclusions" section following each recommendation in the original guideline document.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Early detection and appropriate management of prostate cancer

POTENTIAL HARMS

Adverse effects and complications of treatment, including incontinence, erectile dysfunction, anastomotic stenosis (with surgery), urinary symptoms, proctitis, and acute urinary retention

CONTRAINDICATIONS

CONTRAINDICATIONS

Contraindications for brachytherapy are recent transurethral resection of the prostate, high International Prostate Symptom Score, poor flowmetry and large prostate volume, because this increases the risk of adverse events considerably.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Guidelines are not legal prescriptions, but rather scientifically founded and widely accepted views and recommendations to which healthcare providers would have to adhere to provide quality of care. Given that guidelines are based on 'average' patients, healthcare providers can deviate from the recommendations in the guidelines as necessary in individual cases. Deviation from the guidelines is in fact sometimes necessary if the patient's situation requires it. When there is deviation from the guideline, however, it must be justified, documented, and when necessary, discussed with the patient.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Implementation was considered throughout the various phases of the development of the draft guideline. Draft versions of the guideline were presented to regional urological working groups to assess their feasibility and appropriateness. The guideline was submitted to participating scientific organisations for endorsement and distributed among hospitals, scientific societies, and members of regional working groups of the comprehensive cancer centres. An electronic version of the guideline is available on Oncoline.nl. A summary of the guidelines will also be published in the Dutch Journal of Medicine ("Nederlands Tijdschrift voor Geneeskunde").

The working group recommends that all relevant societies develop an implementation plan that is compatible with the aforementioned initiatives, and subsequently initiate an evaluation of implementation.

The working group recommends converting portions of the guideline into protocols where appropriate, while taking local conditions into account.

IMPLEMENTATION TOOLS

Foreign Language Translations Personal Digital Assistant (PDA) Downloads

For information about <u>availability</u>, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

End of Life Care Living with Illness

IOM DOMAIN

Effectiveness Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2007 Jul 23

GUIDELINE DEVELOPER(S)

Association of Comprehensive Cancer Centres - Disease Specific Society

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GUIDELINE COMMITTEE

Not stated

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A version of the guideline for Personal Digital Assistants (PDAs) is also available at the <u>Association of Comprehensive Cancer Centres Web site</u>.

PATIENT RESOURCES

None available

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